AMERICAN OSTEOPATHIC ASSOCIATION

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Statement of the American Osteopathic Association to the Practicing Physicians Advisory Council

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The American Osteopathic Association (AOA) commends the Practicing Physicians Advisory Council (PPAC) for addressing pay-for-performance (PFP) and its promise and challenges. The AOA recognizes the need to ensure that Medicare spends its resources appropriately. We are receptive to quality reporting and PFP standards in the program. The AOA believes that PFP and other quality-based measures, with the proper focus and resources, have the potential to improve the health of patients. We look forward to working with the Centers for Medicare & Medicaid Services on this issue.

AOA Initiatives

Patient-centered care always has been the philosophy of osteopathic medicine. Founded in 1897, the AOA represents more than 54,000 osteopathic physicians (D.O.s), practicing in 23 specialties and sub-specialties. The philosophy of osteopathic medicine is that the physician, working with the patient, acts as a teacher to help patients take more responsibility for their own well-being, to maintain their health, and change unhealthy patterns. Osteopathic physicians assist patients in developing attitudes and lifestyles that do not just fight illness, but help prevent it. Preventive physical exams, screening services, and patient education all contribute to improving patients' quality of care and health.

The AOA wants to heighten the quality of care that osteopathic physicians (D.O.s) provide to patients and strives to set the example by being aggressive in our quest to improve medical standards. George Thomas, DO, President of the AOA, accordingly has dedicated his term in office to "Patient-Centered Quality Care." We encourage D.O.s to continue practicing under the model of treating the whole patient and not just the symptoms, which has been the

osteopathic philosophy since being founded 130 years ago. Among several initiatives to achieve this goal are the following:

I. Part of our quality initiative is the **Clinical Assessment Program (CAP)**. AOA's CAP measures current clinical practices in family practice and internal medicine osteopathic residency programs for quality improvement. The CAP measure sets include Diabetes Mellitus, Coronary Artery Disease, Women's Health Screening, Childhood Immunizations, Adult Immunizations, Hypertension, and Low Back Pain.

The goal of CAP is to improve patient outcomes by providing valid and reliable assessments of current clinical practices. The CAP identifies opportunities to modify clinical practices through focused education and intervention. Continuous quality improvement is achieved by establishing a baseline for monitoring the effectiveness of treatments performed by physicians in training.

The objectives of the program support each residency program by:

- Providing a structure for quantitative evaluation of current osteopathic care provided individually and in the aggregate by AOA accredited residency programs.
    - To identify strengths and weaknesses in each program's curriculum;
    - To provide osteopathic and national benchmarks to evaluate performance.
- Identifying where quality-of-care improvements can be made in AOA accredited residency programs and to offer assistance to implement improvements.
- Providing residents with "hands on" experience in the execution of observational studies, and opportunities for research and publication of scientific articles by residents, faculty and others.

The AOA currently is developing a similar Clinical Assessment Program for osteopathic physicians for launch July 1, 2005. The CAP for Physicians will measure current clinical practices in the physician's office and will compare the physician's outcome measures to their peers and to national measures. Continuing Medical Education (CME) credit for participating physicians will be integrated into the program. The AOA is also exploring the use of CAP for continuous certification for physicians.

II. The Healthcare Facilities Accreditation Program (HFAP) is the AOA's facility accreditation program with deeming authority from the CMS. HFAP has been providing medical facilities with an objective review of their services since 1945. The AOA has been accrediting healthcare facilities for over 30 years under Medicare. It is one of only two voluntary accreditation programs in the United States authorized by CMS to survey hospitals under Medicare.

New standards to be incorporated in the HFAP program include the nationally developed guidelines for office based surgery, updated Medicare Conditions of Participation for Hospitals incorporating Quality Assessment and Performance Improvement, the Clinical Quality Measurement Program, a new standard on documented verification of the operative site prior to surgery, and the 30 Safe Practices for Better Healthcare by the National Quality Forum (NQF).

III. Collaboration with other organizations dedicated to quality reporting and PFP standards is a third major initiative. The AOA is a member of a number of quality-focused organizations, such as the NQF and the American Medical Association Physician's Consortium on Performance Improvement. The AOA also participates in meetings of The Leadership Project convened by Agency for Healthcare Research and Quality (AHRQ), America's Health Insurance Plans, the American Academy of Family Physicians (AAFP), and the American College of Physicians (ACP).

In addition, the AOA aggressively interacts with most the country's largest national health plans such as Aetna, America's Health Insurance Plans (AHIP), Blue Cross/Blue Shield Association, CIGNA, and United HealthCare regarding quality and performance measures. We are trying to learn about the programs carriers develop and at the same time influence them.

Concerns and Recommendations

For any quality or performance initiative to succeed, the focus must remain on the patient. We encourage Congress and CMS to ensure that appropriate resources are available for quality and PFP initiatives to alleviate the potential for program interruptions that ultimately could harm patient care. Five concerns and recommendations are predominant:

I. Payment: Medicare's current payment formula, in particular the Sustainable Growth Rate (SGR), is flawed and unstable. The estimated payment update for 2006 is a negative 4.3 percent. Additional reductions are projected for several years thereafter.

The Medicare payment formula does not account adequately for changes in laws and regulations that are beneficial to patient care. New benefits mean new costs to physicians who provide those benefits. Medicare coverage decisions influence patient demand and patients seek more medical visits, which generate additional tests and care. The SGR targets do not account for the increased use of services that result when screenings reveal health problems.

The current payment update formula penalizes physicians for providing the services and benefits that the government promotes. Improving quality of care likely will result in greater spending on preventive services. Components of PFP such as following clinical guidelines should result in a decrease in volume of other more expensive services, which would offset the increased spending in preventive care. Any changes to the current Medicare payment methodology must not penalize physicians. Additional funding should be made available for physicians who demonstrate improved care.

II. Regulatory reform: Another factor taking its toll on the nation's health care system is the regulatory burden. In *Crossing the Quality Chasm*, the Institute of Medicine characterizes regulation as "a dense patchwork that is slow to adapt to change. It is dense because there is a forest of laws, regulations, agencies, and accreditation processes through which each care delivery system must navigate at the local, state, and federal levels." [i]

When Gov. Tommy Thompson took office as HHS Secretary, regulatory reform was one of his top concerns. He stated: "When we flood doctors and hospitals with excessive paperwork, patients suffer the consequences."[ii] He established the Secretary's Advisory Committee on Regulatory Reform, which issued its 255 recommendations in 2002. The committee's work was a positive beginning. However, more action is necessary. Regulatory reform must remain a top priority.

We commend CMS for its efforts to address the current demands on the physician community. Physician Regulatory Issues Team (PRIT), MedLearn Matters, Open Door Forums, provider partnerships, the CMS web site and implementing provisions of the Medicare Modernization Act to improve contractor performance and provider customer service are positive steps in improving relations with the physician community and alleviating confusion and inconsistencies regarding Medicare requirements.

Congress and CMS must continue and increase their efforts to reduce current regulatory and administrative demands on the physician and hospital community. The quality of health care

suffers when regulatory requirements drain time, money and resources from patient care. In addition, Congress and CMS must ensure that quality and PFP initiatives do not create new demands that take essential time and resources away from actual patient care.

III. Health Information Technology (HIT): Computer technology plays a prominent role in quality measurement and pay for performance. HIT provides instant access to the latest information on evidence-based medicine and to a patient's electronic health records. It is considered an important tool for reducing medical errors and improving coordination of care.

The AOA is committed to advancing the development and utilization of information technology to improve the quality and efficiency of the healthcare delivery system. We believe that HIT, if developed and implemented in conjunction with the physician community and other stakeholders, offers great promise. AOA supports CMS's Doctors' Office Quality - Information Technology (DOQ-IT) project. PPAC member Geraldine O'Shea, DO is a participant in the DOQ-IT project.

However, several barriers prevent the adoption of HIT. Currents laws and regulations need to be reformed to allow collaboration between physicians and hospitals in the pursuit of electronic health records systems. Grants, tax credits and bonus payments should be made available to help small physician practices adopt HIT.

While the AOA supports HIT, how computer technology is used and controlled in health care raises concerns about a patient's privacy, safety, confidentiality and the doctor/patient relationship. Darryl Beehler, DO, chairman of AOA's Technical Advisory Committee, recently testified before the National Committee on Vital & Health Statistics' Subcommittee on Privacy and Confidentiality. "Special attention must be given to the impact the network will have on the physician-patient relationship and the security of patient information. The benefit of HIT and the patient data contained therein must balance potential benefits against the potential misuse of patient data in violation of the patient's privacy," said Dr. Beehler.[iii]

Users of HIT also must be aware that recent studies show computerized errors are on the rise. A U.S. Pharmacopeia study found E-prescribing mistakes accounted for almost 20% of all hospital and health system medication errors in 2003.[iv] "Computer entry errors were the fourth leading cause of medication errors in U.S. hospitals and health systems," according to USP. [v]

A study of computerized physician order entry (CPOE) systems used between 1997 and 2004 at the Hospital of the University of Pennsylvania found 22 types of persistent errors such systems are

supposed to prevent, according to a *Washington Post* article. Among the mistakes: "Incorrect doses prescribed for patients; patients who failed to get medication in a timely manner because of computer-related problems; and difficulty determining which patient was supposed to get a drug that had been prescribed."[vi]

IV. Physician leadership: Physicians must take the lead in developing, updating and implementing any initiative to improve the quality of care. Third-party influences could lead to greater loss of physician autonomy, more interference with clinical judgment, added regulatory/administrative burdens, the stifling of innovation, and the demise of individualized care.

The use of evidence-based medicine (EBM) will improve patient care. However, mechanisms must be in place to ensure that the guidelines being used are the most current. "In 2000, a group of researchers determined that more than 75% of the guidelines developed between 1990-96 needed updating. In addition, they discovered that half of the guidelines were outdated in 5.8 years," according to a report by the Citizens Council on Health Care. [vii]

In addition, physicians must have the flexibility to use their clinical judgment when providing care to a patient. What may be best for the population overall, may not be appropriate for individuals. The consequence could be the undermining of patient-centered, patient-focused care.

V. Patient responsibility: Osteopathic physicians teach their patients to take more responsibility for their own well-being, to maintain their health, and change unhealthy patterns. Outcomes not only rely on the performance of the physician or hospital, but also on that of the patient. If the patient refuses to follow the specified care, how will the patient's performance affect the pay incentives and cost efficiencies of PFP?

Conclusion

The American Osteopathic Association has taken a leadership role on PFP and quality-based measures through several initiatives. Caution should be taken, however, so that the call for "patient-centered, patient-focused" care does not become "cost-centered, cost-focused" care. Clinical judgment and medical decision-making should be determined by the patient's needs. Payment incentives should not make the health care provider more beholden to the payer of those incentives than to the patient entrusted in his/her care.

IOM's statement that "payment policies are a strong influence on how health care organizations and professionals deliver care"[viii] is telling. Current payment policies, in addition to

third-party influences over the practice of medicine, have contributed to the deterioration of health care by de-valuing medicine and the physicians who provide it.

To reverse this deterioration, the physicians must take the lead in developing and implementing any initiative to improve the quality of care and maintain control over medical information relating to their patients. In addition, patients must bear greater responsibility for their health care. Only then, will health care become truly patient-centered and patient-focused.

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[i] *Crossing the Quality Chasm*, Institute of Medicine, pg. 214

[ii] *Bringing Common Sense to Health Care Regulation*: Report of the Secretary's Advisory Committee on Regulatory Reform, 2002

[iii] AOA testimony before the National Committee on Vital and Health Statistics Subcommittee on Privacy and Confidentiality, March 31, 2005

[iv] *Medication Errors Attributable to Computerized Prescribing Increasing*; BNA Health Care Policy Report, Vol. 13, No.l; 1/3/05

[v] *Medication Errors Attributable to Computerized Prescribing Increasing*; BNA Health Care Policy Report, Vol. 13, No.l; 1/3/05

[vi] *Not Quite Fail-Safe*, Sandra Boodman, Washington Post, March 22, 2005

[vii] *How Technocrats are Taking over the Practice of Medicine*, Jan. 2005; Twyla Brase, RN President; Citizens' Council on Health Care, pg. 9

[viii] *Crossing the Quality Chasm*; Institute of Medicine, pg. 181